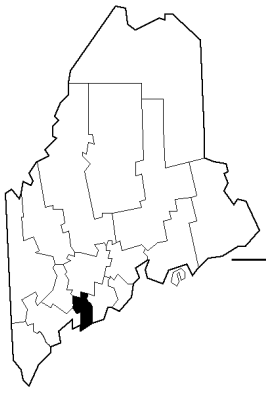
Community Health Profile 2000

Sagadahoc County



Community Health Profile 2000

A report on adult health behaviors
in Sagadahoc County, Maine
as of December 2000.

A collaborative project of MaineHealth,
MaineGeneral Health, the Maine Bureau of Health,
and the Maine Center for Public Health.

Published March 2002

Acknowledgements

THE COMMUNITY HEALTH PROFILE PROJECT, which resulted in the publication of 10 separate county-level reports containing local health data, is the first such project of its type ever undertaken in Maine. This ambitious effort was the result of more than two years of diligent planning and collaboration among a great many individuals and organizations across the State.

MaineHealth, a nonprofit health system that encompasses the ten counties of southern, central, and western Maine, provided the primary leadership and funding for the conduct of the oversampling that allowed county-level data analysis to be performed. Deborah Deatrick, MPH and Robert McArtor, MD, MPH were principal participants for MaineHealth. MaineGeneral Health, a nonprofit health system that is located in Kennebec County and is an affiliate of the MaineHealth system, also contributed substantial financial and human resources to the project. Natalie Morse and Stephen Sears, MD, MPH were principal participants for MaineGeneral Health.

The Maine Bureau of Health, under whose auspices the Behavioral Risk Factor Surveillance System has been conducted since its implementation in Maine in 1987, also provided considerable financial and human resources. Principal participants for the Bureau were Dora Ann Mills, MD, MPH, Dorean Maines, Warren Bartlett, Barbara Leonard, MPH and Judith Graber, MS. Karen O'Rourke, Program Director of the Maine Center for Public Health coordinated planning and production of the reports, as well as the Advisory Committee. Other key individuals who contributed to the project were Ken Liberty and Peter Mariolis of the US Centers for Disease Control, James Dayton, Principal of Macro Associates, and John O'Brien of O'Brien Design.

Members of the project advisory committee included Patricia Cook, Western Maine Healthcare; Natalie Morse and Stephen Sears, MaineGeneral Health; Ginger Collins, St. Andrews Healthcare; Terrance Sheehan, MD, Southern Maine Medical Center; Marjorie Stone, Mercy Hospital; Marla Davis, MidCoast Hospital; Jim Donovan, MainePartners Health Plan; Brian Hill, Miles Healthcare; Jim Kupel; Robert Gammelin, Cindy Swift; and Dorean Maines, Bureau of Health.

Finally, financial contributions to produce the report from Inland Hospital in Waterville, Goodall Hospital in Sanford, and Southern Maine Medical Center in Biddeford are gratefully acknowledged.

To obtain additional copies of this report, please contact MaineHealth, 465 Congress Street, Suite 600, Portland, Maine 04101 or visit either the MaineHealth website, www.mainehealth.org or the Maine Center for Public Health website, www.mcph.org

For more information about the data included in the report or to request data on other BRFSS measures, please contact Judith Graber in the Maine Bureau of Health at (207) 287-1420 or visit the national BRFSS website at www.cd.gov/nccdphp/brfss.

MaineHealth is a growing family of healthcare services that consists of hospitals, physician practices, long-term care facilities, home care agencies, and support services serving southern, central, and western Maine. We are committed to working together so our communities are the healthiest in America.

Contents

Introduction

The importance of chronic disease indicators

Chronic diseases and injury account for the vast majority of premature death, illness and disability among Maine residents. Behaviors linked to these health problems and some health characteristics, whether personal or the result of cultural or economic conditions, are referred to as behavioral risk factors. Example of behavioral risk factors include cigarette smoking, overweight, uncontrolled hypertension, high cholesterol, lack of physical activity, lack of safety belt use, heavy alcohol consumption, and non-utilization of preventive health-screening such as mammography. Behavioral risk factors are often the only indicators available to understand the potential burden of chronic disease and to use for planning, implementation and evaluation of public health intervention and control programs that target the prevention of chronic disease.

A description of the Behavioral Risk Factor Surveillance System

To determine behavioral risk factors for chronic and communicable diseases and injury, the Maine Bureau of Health (BoH) uses the Behavioral Risk Factor Surveillance System (BRFSS). Maine is one of 50 states and territories that conduct the BRFSS. BRFSS is conducted in collaboration with, and partially funded by, the Centers for Disease Control and Prevention. BRFSS is an ongoing statewide telephone survey. Maine has conducted the BRFSS survey annually since 1987.

The BRFSS annually surveys approximately 2400 Maine residents aged 18 and older. Everyone in Maine with a telephone has an equal chance of being called. The results are used to estimate the true prevalence of behavioral risk factors, diseases and injury for the entire adult population of Maine.

The 2400 people interviewed each year for Maine BRFSS give good estimates of behavioral risk factors and disease prevalence in the state of Maine. However, to have enough people to estimate this information for each county, the BoH has traditionally combined 5 years of data.

How this report was created

In 2000, the BoH was approached by MaineHealth, a nonprofit health system that serves the ten counties of southern, central, and western Maine (representing about three-fourths of the state's population) and entered into an exciting partnership to increase the number of people surveyed and as a result, to create more "actionable" data to inform local or regional community health improvement activities.

MaineHealth and MaineGeneral contracted with the Maine Center for Public Health (MCPH) to coordinate the project between the various collaborators. MCPH contracted with Macro International,

a firm that conducts BRFSS surveys for a number of states, to complete the additional surveys that were then combined with the BOH surveys to produce the final number. The goal of the extra surveys (called an oversample) was to be able to produce county-level risk factors for Maine's most populated counties with just one year of survey results. The collaboration resulted in a total of 4601 people surveyed in that year alone. As a result, behavioral risk factors have been estimated for ten of Maine's counties, those counties that comprise MaineHealth's region, for 2000.

An Advisory Committee was formed in the spring of 2000 to review the BRFSS questionnaire and to select the most important indicators for the report. The Committee identified a list 12 indicators that were felt to represent the priorities in their communities and which communities could take action to address through programs or policies. Those indicators are reflected in this report however the BRFSS contains many other data elements that may be useful for communities. See the Appendix for a list of BRFSS topics and the Acknowledgments section for Bureau of Health contact information to obtain results for other indicators. The text of this report and more complete data files may be found on the MaineHealth web site, www.mainehealth.org.

What was found?

The risk factors for most counties are similar to the state with the following exceptions:

County	Risk Factor	Higher or Lower than Maine
Franklin	Currently smoke tobacco	Lower
Knox	Currently smoke tobacco	Lower
Lincoln	Overweight and Obesity	Higher
Oxford	Overweight and Obesity	Higher
Cumberland	No health insurance in the past year	Lower
Sagadahoc	No health insurance in the past year	Lower
Cumberland	Health status fair or poor	Lower

Although it is not expected that an oversample will be done on a yearly basis, providing one year of risk factor data has uncovered important differences that will help communities plan interventions to improve health status. MaineHealth and its partners, including the Advisory Committee to this project, have recommended to the BOH that an oversample of the BRFSS in each county should be conducted at least every five years to allow benchmarking and trend analyses.

Interpreting the numbers

Getting the "right" number

Since different people are selected for each survey, two identical surveys may not get the exact same estimate of the same behavioral risk factor. For example, if we asked 2400 Mainers if they smoke and then ask another 2400 Mainers if they smoke, the number who say "yes" might be different in each group, even though the number of people who smoke throughout Maine has stayed the same.

How to be sure it's a good estimate – Confidence Intervals

Because approximately 2400 people are surveyed each year, the answers from the survey usually provide a good approximation of the underlying truth. However, there is a range of values that may be consistent with the true value. This range is called a confidence interval. A 95% confidence interval is a range of values that has a 95% chance of including the true value. The confidence interval describes how precise the estimate is. If the confidence interval is very wide, the estimate is less reliable. If the confidence interval is very narrow, the estimate is more reliable. The main factor affecting the width of the interval is the number of people surveyed. The more people surveyed, the more narrow the confidence interval and the more reliable the estimate.

Are the numbers different?

When 50 or more people are asked a question, a confidence interval can usually be used to determine if two numbers are different from each other or just look different because a different sample of people were asked the same question. (Technical note: Confidence intervals are not a true test of statistical significance but can be used to estimate statistical difference when numbers are large enough.)
In general, if the confidence intervals around numbers overlap, then the numbers are not statistically different. If the confidence intervals do not overlap, then the numbers are truly different.

➢ Here's an example from the percent of overweight people in Maine for from the 2002 BRFSS:
Let's say the question is: **Are there more overweight people in *Lincoln* county than in Maine?**

	Percent	95% Confidence Interval
Maine	56.7%	54.2% - 59.2%
Lincoln County	65.3%	59.7% - 70.8%

The percent of overweight people in Maine is 56.7%. The 95% confidence interval is 54.2% to 59.2%. The percent of overweight people in Lincoln County is 65.3%. The 95% confidence interval is 59.7% - 70.8%. Since these two confidence intervals don't overlap, the answer is:
YES – the percent of people who are overweight in Lincoln County is statistically significantly higher then the percent of people who are overweight in Maine.

➢ Here's another example: **Are there more overweight people in *Knox* county than in Maine?**

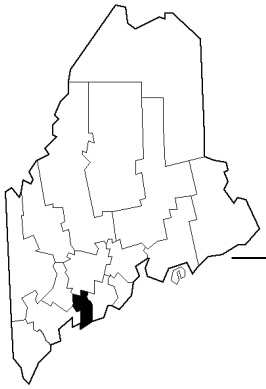
	Percent	95% Confidence Interval
Maine	56.7%	54.2% - 59.2%
Knox County	57.3%	51.5% - 63.2%

The percent of overweight people in Maine is 56.7%. The 95% confidence interval is 54.2% to 59.2%. The percent of overweight people in Knox County is 57.3%. The 95% confidence interval is 51.5% - 63.2%. Since these two confidence intervals do overlap, the answer is:
NO – the percent of people who are overweight in Knox County is statistically not different than the percent of people who are overweight in Maine.

Remember, the main factor affecting the width of the interval is the number of people surveyed, so the more people in the survey, the more likely to be able to see a true difference between percentages.

Using this report

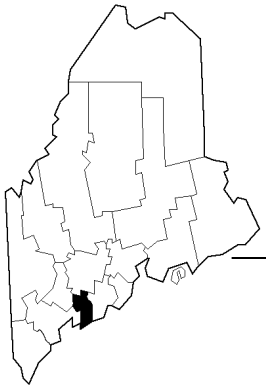
This report includes a summary of selected demographic measures for the county, followed by single page summaries for each of the 12 selected indicators. The topic appears in large, bold type (such as "Nutrition"), and the wording of the question from the survey appears underneath. A bar chart compares results of that individual question for the county, the State of Maine, and the United States (where available). The actual percentages, numbers, and confidence intervals are presented in a separate chart at the bottom of the page. The sidebar provides a quick summary of the issue, as well as relevant websites that can provide further information.



Sagadahoc County

	Sagadahoc County	Maine
Population, 2000	**35,214**	**1,274,923**
Percent under 18 years	**25.8**	**23.6**
Percent 18 – 24 years	**6.6**	**8.1**
Percent 25 - 44 years	**30.5**	**29.1**
Percent 45 – 64 years	**24.9**	**24.8**
Percent 65 years and over	**12.3**	**14.4**
Median age	**38.0**	**38.6**
White persons, percent	**95.9**	**96.9**
Female population, percent	**50.9**	**51.3**
Median household income	**$39,991**	**$33,140**
Persons below poverty, percent	**7.8**	**10.7**
Children below poverty, percent	**11.0**	**14.9**

Source: US Census
For more information: www.census.gov



Health status

Respondents who reported that, in general, their health is fair or poor.

Proportion of adults who report their health is fair or poor*

When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who reported that, in general, their health is fair or poor.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	11.9	41	(8.1-15.7)
Maine	14.8	677	(13.0-16.6)
US	13.5	NA	NA

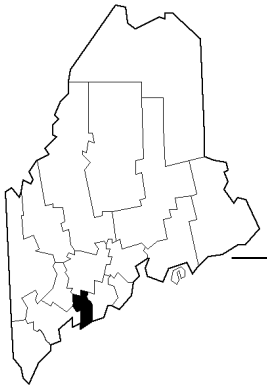
Americans have longer lives than ever before. Those who survive to age 65 can expect to live an average of nearly 18 more years. The health of older people varies greatly. Rates of illness and disability increases sharply among the "oldest old" (85 years of age and older) compared with younger individuals.

Despite overall declines in mortality, disparities exist among racial and ethnic groups for many causes of death.

One tool to assess health-related quality of life is called a "global assessment" in which an individual rates his or her health as "excellent", "very good", "good", "fair", or "poor."

This measure can be a reliable indicator of health status.

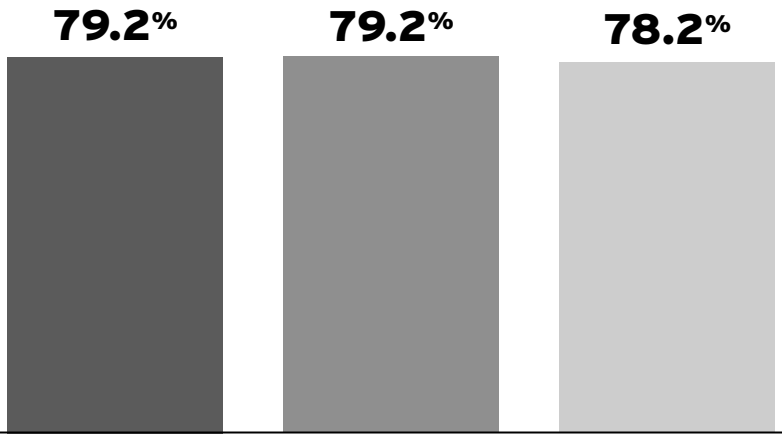
For more information, see the CDC's website: *www.cdc.gov*



Physical activity

Respondents who reported no physical activity or less than 30 or more minutes, five or more times per week.

Proportion of adults who report being physically inactive*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who reported no physical activity or less than 30 or more minutes, five or more times per week.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	79.2	277	(74.0-84.3)
Maine	79.2	3627	(77.2-81.1)
US	78.2	NA	NA

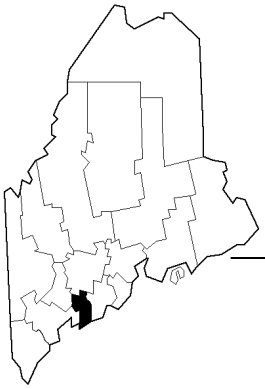
Physical activity decreases the risk of early death in general and of heart disease, diabetes, colon cancer, high blood pressure, obesity, osteoporosis, muscle and joint disorders, and symptoms of anxiety and depression in particular.

Among the other benefits of regular physical activity are improved strength and endurance, healthy bones and muscles, and weight control.

Moreover, physical activity need not be strenuous to be beneficial; men and women of all ages benefit from moderate physical activity, such as 30 minutes of brisk walking five or more times a week.

Despite the proven benefits of being physically active, 28% of U.S. adults are sedentary.

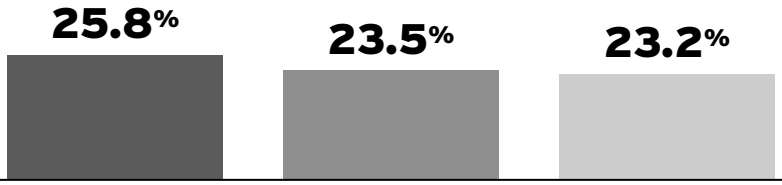
For more information see the Surgeon General's report on Physical Activity and Health: *www.cdc.gov/nccdphp/sgr/sgr.htm*



Tobacco use

Respondents who reported smoking at least 100 cigarettes in their lifetime and now smoke.

Proportion of adults who report currently smoking cigarettes*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who have ever smoked 100 cigarettes in their lifetime and reported smoking every day or some days.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	25.8	90	(19.7-31.9)
Maine	23.5	1075	(21.3-25.6)
US	23.2	NA	NA

Tobacco use is the single most preventable cause of death and disease in the United States.

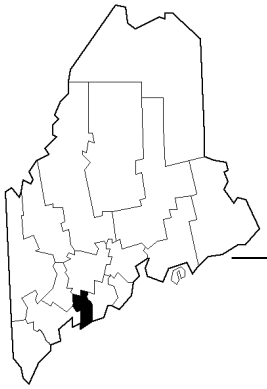
Tobacco use increases the risk for lung and other cancers as well as for cardiovascular and respiratory diseases.

Smoking cessation has major and immediate health benefits for men and women of all ages, regardless of whether they have a smoking-related disease.

Seven Maine people die every day from tobacco-related illness – one of them a nonsmoker who dies because of exposure to secondhand smoke.

Smoking during pregnancy can lead to miscarriages, premature delivery, low birth weight and Sudden Infant Death Syndrome (SIDS).

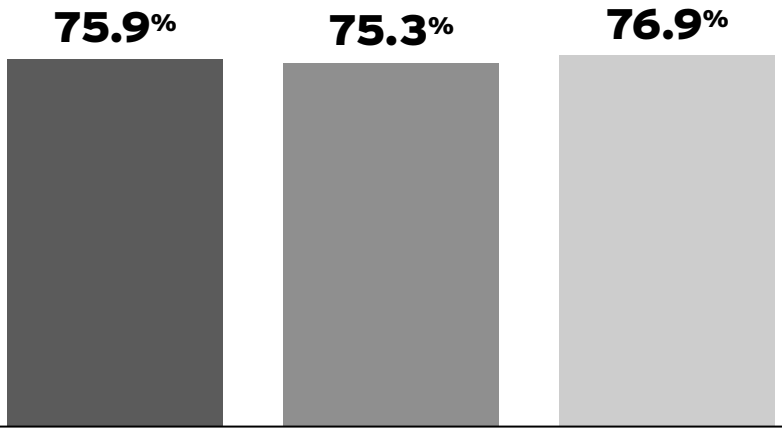
For more information see the Surgeon General's reports on tobacco: *www.cdc.gov/tobacco*



Nutrition

Respondents who reported they consumed less than 5 servings of fruits and vegetables per day.

Proportion of adults who did not eat the recommended servings of fruits and vegetables*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who reported not eating 5 or more fruit and vegetable servings per day.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	75.9	266	(70.3-81.4)
Maine	75.3	3449	(73.3-77.2)
US	76.9	NA	NA

Good nutrition, including a diet that is low in saturated fats and includes five or more servings of fruits and vegetables each day, plays a key role in maintaining good health.

Improving the American diet could extend productive life span and reduce the occurrence of chronic diseases, including total cardiovascular diseases, diabetes, and cancer.

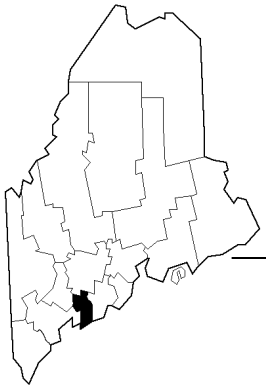
According to the American Cancer Society, of all cancer deaths, approximately 30% are attributable to dietary risk factors.

Poor nutrition and lack of physical exercise are associated with 300,000 deaths each year, making these factors second only to tobacco use as a preventable cause of death.

In 1998, less than one-fourth of U.S. adults reported eating recommended amounts of fruits and vegetables daily.

For more information on nutrition see the National Cancer Institutes 5 A Day website: *www.dccps.nci.nih.gov/5aday*

Compared with Maine and the United States

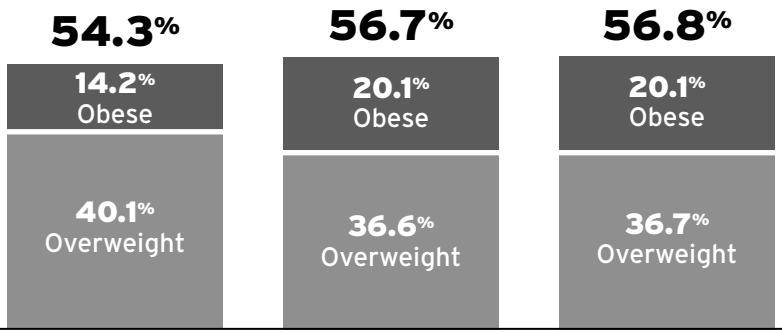


Overweight and obesity*

Overweight = *Body mass index equal to or greater than 25.0 but less than 30.0.*

Obese = *Body mass index equal to or greater than 30.0.*

Proportion of adults who are overweight (and the proportion who are obese)*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*Overweight = Body mass index equal to or greater than 25.0 but less than 30.0.
Obese = Body mass index equal to or greater than 30.0.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent Overweight	Percent Obese	Total	Number	95% CI
Sagadahoc	40.1	14.2	54.3	190	(47.2-61.3)
Maine	36.6	20.1	56.7	2598	(54.2-59.2)
US	36.7	20.1	56.8	NA	NA

A growing obesity epidemic is threatening the health of millions of Americans.

Obesity and overweight are linked to cardiovascular disease, the nation's leading cause of death, as well as to diabetes, some cancers, and other chronic conditions.

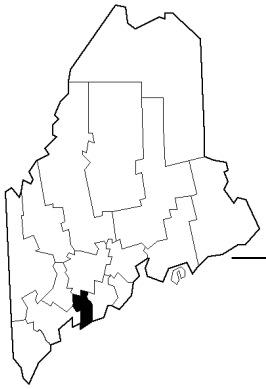
Men were more likely than women to be overweight according to self-reported height and weight.

Almost one in five Maine people now are considered obese.

Obesity rates have increased by 40% in only 10 years in Maine.

For more information see the American Heart Association's Medical Scientific Statement Understanding Obesity in Youth: *www.americanheart.org/Scientific/statements/1996/1202.html*

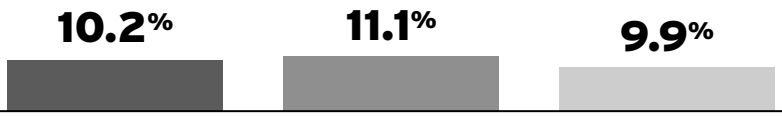
And the CDC: *www.cdc.gov/nccdphp/dnpa/obesity/index.htm*



Medical care costs

Respondents who reported that cost was a barrier to getting health care.

Proportion of adults for whom cost was a barrier to getting health care*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who said there was a time during the last 12 months she/he needed to see a doctor but could not because of cost.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	10.2	36	(6.0–14.3)
Maine	11.1	508	(9.6–12.6)
US	9.9	NA	NA

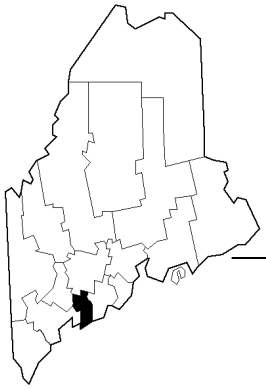
The cost of medical care in the United States as of 1997 totaled over $1 trillion, more than any other industrialized country.

The Year 2000 Blue Ribbon Commission estimated that almost $5 billion was paid in Maine from all sources for personal health care.

Those covered by private insurance in Maine pay 37.5% of their costs out-of-pocket, those covered by Medicare pay 32% and those covered by Medicaid pay .6%. The uninsured pay for health care costs out-of-pocket, and these expenses compete with basic necessities like food and housing.

The cost of prescription drugs has skyrocketed in the past few years, making it increasingly difficult for Mainers to pay for the medications they need.

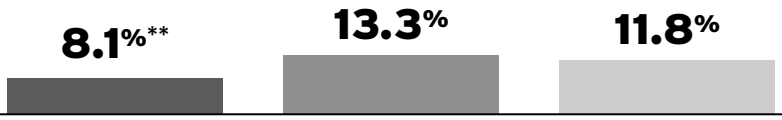
For more information, see the CDC website: *www.cdc.gov/nchs/data/hus99.pdf*



Access to healthcare

Respondents who reported currently having no kind of health care coverage.

Proportion of adults who currently have no kind of health care coverage*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who reported currently having no kind of health coverage.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

** Statistically lower than the state of Maine.

	Percent	Number	95% Confidence Interval
Sagadahoc	8.1	28	(5.1–11.1)
Maine	13.3	609	(11.6–15.1)
US	11.8	NA	NA

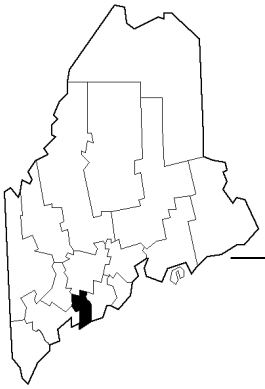
Without health coverage, Americans are three to four times more likely to report problems getting needed medical care, even for serious conditions, according to a recent report from the Kaiser Commission.

Maine has the highest three-year average uninsured rate (13%, between 1997 and 1999) of all New England states.

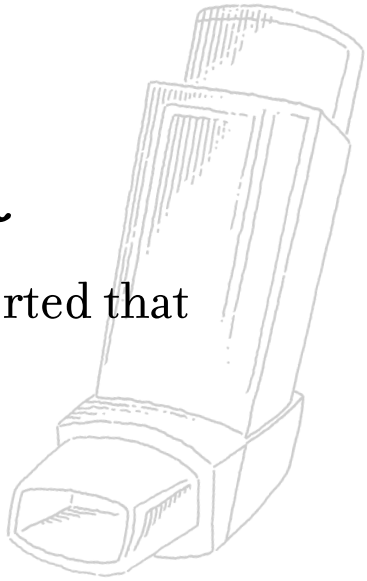
Twenty-one percent of Maine citizens who have income below the poverty line report that their health is fair or poor, which is four times greater than uninsured people above the poverty line, according to research conducted by the Muskie School of Public Service.

For more information about the insurance problem see the Kaiser Family Foundation website: *www.kff.org*

For information about CarePartners, a new community based access to care program sponsored by MaineHealth and its partners, see *www.mainehealth.org*



Asthma



Respondents who reported that they have asthma now.

Proportion of adults who report having asthma*

When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who reported that they have asthma now (asked of those responding that they ever had asthma).

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	9.8	34	(5.6–14.0)
Maine	8.9	409	(7.6–10.3)
US	7.5	NA	NA

Asthma is a chronic lung disease that is characterized by symptoms of wheezing, cough, chest tightness, and difficulty breathing.

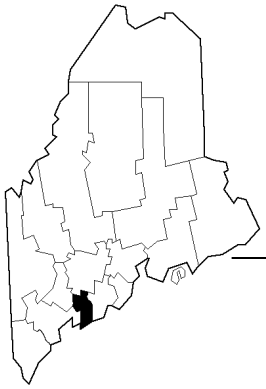
Asthma is among the most common chronic diseases in the United States.

Asthma accounts for nearly 500,000 hospitalizations each year in the US and asthma deaths have tripled over the past two decades.

Maine has the highest rate of current asthma among adults in the country at 8.9%.

The prevalence of asthma decreases with increasing family income; exposure to environmental tobacco smoke increases the risk of asthma, particularly among children.

For more information on asthma see the National Center for Environmental Health's Asthma website: *www.cdc.gov/nceh/asthma/ataglance/default.htm* or the American Lung Association of Maine's: *www.mainelung.org/learn_with_us/asthma/asthma.htm* or to learn more about an innovative, community-based asthma management program called AH! Asthma Health, visit the MaineHealth website:*www.mainehealth.org*



Diabetes

Respondents who reported having ever been told by a doctor that they have diabetes.

Proportion of adults who report having diabetes*

When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who reported having ever been told by a doctor that they have diabetes.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

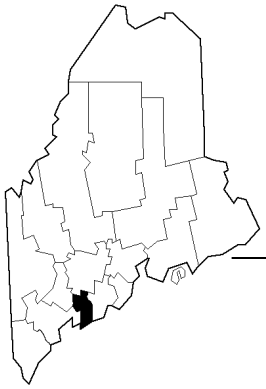
	Percent	Number	95% Confidence Interval
Sagadahoc	6.3	22	(3.3-9.4)
Maine	6.1	280	(5.0-7.3)
US	6.0	NA	NA

Diabetes mellitus is a disease caused by a deficiency of insulin, which is a hormone secreted by the pancreas.

Diabetes is classified into two main types: type 1 and type 2. Type 1 diabetes (insulin-dependent) most often occurs during childhood or adolescence. Type 2 diabetes (non-insulin- dependent) is the more common type, affecting 90%-95% of those with diabetes, and usually occurs after age 40.

Cardiovascular disease is 2-4 times more common among persons with diabetes; the risk of stroke is 2-4 times higher; 60%-65% have high blood pressure; and up to 70% have mild to severe diabetic nerve damage.

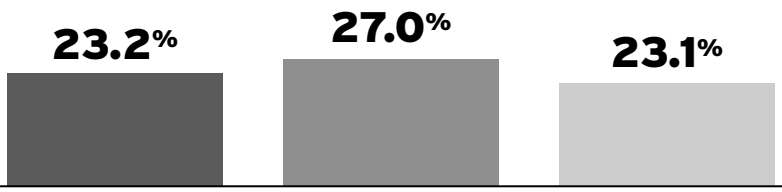
For more information see the CDC website: *www.cdc.gov/nccdphp/diabetes.htm* or the American Diabetes Association website: *www.diabetes.org*



Hypertension

Respondents who reported having been told by a doctor, nurse, or other health professional that they have high blood pressure.

Proportion of adults who report having high blood pressure*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 18 and older who reported having ever been told by a doctor that they have high blood pressure.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	23.2	81	(17.4-29.0)
Maine	27.0	1238	(24.9-29.2)
US (1999)	23.1	NA	NA

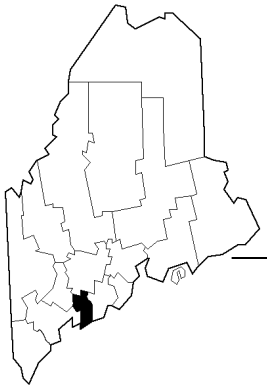
Hypertension is the medical term for high blood pressure. It is defined in an adult as a blood pressure greater than or equal to 140 mm Hg systolic pressure or greater than or equal to 90 mm Hg diastolic pressure.

High blood pressure directly increases the risk of coronary heart disease, which leads to heart attack and stroke, especially along with other risk factors.

Early detection of high blood pressure can prevent stroke as well as less common cardiovascular disorders such as kidney failure.

The need for identifying and controlling high blood pressure is especially acute in people with diabetes, who are at greatest risk for diseases related to high blood pressure.

For more information see the National Heart Lung and Blood Institute website: *www.nhlbi.nih.gov/hbp/index.html* or the American Heart Association: *www.americanheart.org*



Mammogram

Women respondents, 40 years and older, who reported not having a mammogram in the last two years.

Mammography screening is the most effective method for detecting breast cancer early, before it has spread.

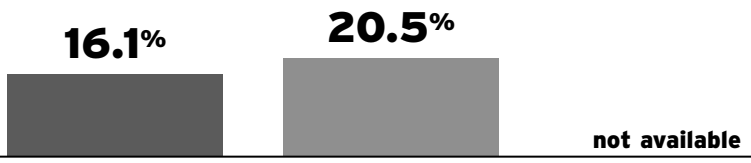
The American Cancer Society recommends that women aged 40 years or older have an annual mammogram, an annual clinical breast exam, and a monthly breast self-examination.

Women age 65 and older are less likely to get mammograms than younger women even though breast cancer risk increases with age.

Women below poverty level are less likely than women at higher incomes to have had a mammogram within the past two years (44 percent versus 65 percent, respectively).

For more information on mammography and breast cancer see the following websites: the National Cancer Institute *www.nci.nih.gov/* the American Cancer Society *www.cancer.org* or the National Breast Cancer Coalition *www.natlbcc.org/*

Women, 40 years and older, who reported not having a mammogram in the last 2 years*

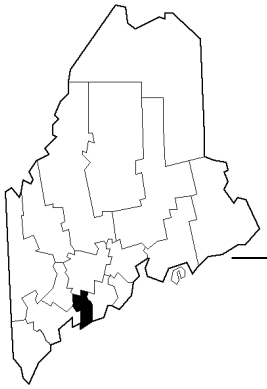


When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*All respondents 40 and older who reported not having a mammogram in the last 2 years.

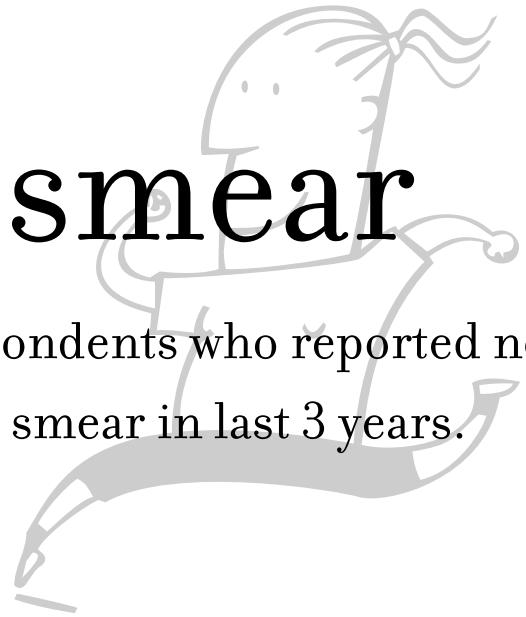
Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	16.1	56	(8.3-23.8)
Maine	20.5	938	(17.3-23.7)
US	NA	NA	NA

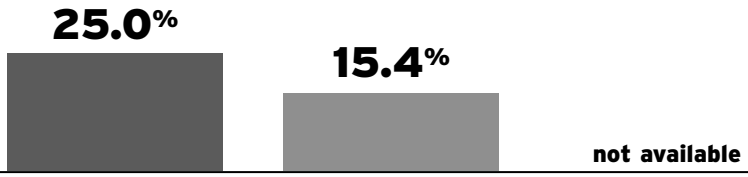


Pap smear

Women respondents who reported not having a pap smear in last 3 years.



Women, 18 Years and older, who reported not having a pap smear within the last 3 years*



When the number of people responding to a question is less than 50, the percent should not be generalized to the state of Maine or any other population.

*Female resondents, with uterine cervix, age 18 and older, report that they did not have a pap smear within the last three years.

Denominator includes all survey respondents except those with missing, don't know, and refused answers.

	Percent	Number	95% Confidence Interval
Sagadahoc	25.0	87	(14.6-35.3)
Maine	15.4	705	(13.1-17.6)
US	NA	NA	NA

Since the introduction of the Pap test in the 1950s, incidence and mortality rates for cervical cancer have decreased markedly.

When detected early, cervical cancer is one of the most successfully treatable cancers with a 5-year survival rate of 92%.

While screening is overall rates are high, there is variability in different demographic subgroups. For example, women aged 60 years and older, Hispanic women, women with an annual household income less than $10,000, women with less than a high school education, and women without health insurance were less likely to have a pap test.

For more information see the National Cancer Institute *www.nci.hih.gov* or the American Cancer Society *www.cancer.org*

APPENDIX

Community Resources

Community Health Improvement Initiatives: Working in collaboration with the Bureau of Health's Community Health Promotion/Chronic Disease Prevention Program, including Healthy Community Coalition (HCC) and Planned Approach to Community Health (PATCH) programs.

Richmond Area Healthy Communities
Carol Browne
24 Gardiner Street
Richmond, ME 04357
Tel: 737-4359
Fax: 737-4412
E-mail: richhc@ctel.net

Healthy Maine Partnerships: In cooperation with and funded by the Maine DHS Bureau of Health, community and school tobacco grantees coordinate with the local health care delivery system, education system and other appropriate community members and community organizations to achieve the goal of reducing tobacco related chronic diseases.

ACCESS Health
Linda Christie
66 Baribeau Drive, Suite 5A
Brunswick, Maine 04011
Tel: 373-6973
Fax: 373-6974
E-mail: access@midcoasthealth.com

Getting Healthy in Southern Kennebec
Joanne Joy
27 Mechanic Street #2
Gardiner, ME 04345
Tel: 582-8011
Fax: 582-5804
E-mail: jjoy@gwi.net

Communities for Children: In partnership with State government, CFC programs assess and address the needs of children, youth and young adults from birth to age 18 (or 24).

Bath Communities for Children
Rob Ellis
C/O KVMHC, 37 Stone Street
Augusta, ME 04330
Tel: 629-9010 ext 3003
Fax: 629-9083
E-mail: robellis@gwi.net

United Way of Mid Coast Maine
Peter Lindsay
746 High Street
Bath, ME 04530
Tel: 443-9752
Fax: 443-9794
E-mail: plindsay@uwmcm.org

Mt. Ararat Middle School
Bette Manchester
36 Spring Street
Brunswick, ME 04011
Tel: 729-2950
Fax: 729-2964
E-mail: manchesb@link.75.org

APPENDIX

BRFSS Questions

(for the survey conducted in calendar year 2000)

CORE SECTIONS (Questions by every state)

Section 1: Health Status (rating general health, days when health and mental health not good)

Section 2: Health Access (health insurance coverage, cost as barrier to seeking care, length of time since obtaining routine checkup)

Section 3: Asthma (ever had asthma, have asthma now)

Section 4: Diabetes (have diabetes)

Section 5: Care Giving (providing care to family member or friend over 60, who would you call if someone needed care)

Section 6: Exercise (participate in exercise, how much, how often, types of activities)

Section 7: Tobacco Use (ever smoke, now smoke, how much, ever/ quit, time since quitting)

Section 8: Fruits and Vegetables (how many servings)

Section 9: Weight Control (try to lose weight and how, received advise from health profession about weight)

Section 10: Demographics (age, race, ethnicity, martial status, children, education, income, military status, height, weight)

Section 11: Women's Health (mammogram, clinical breast exam, Pap)

Section 12: HIV/AIDS (education in school about HIV/AIDS, chances of getting infected with HIV, blood donation, ever tested for HIV – where and why)

MODULES (Questions asked by some states)

Module 1: Diabetes (treatment, management and monitoring)

Module 7: Hypertension Awareness (when had blood pressure taken, have high blood pressure, medications)

STATE-ADDED (Questions asked only in Maine)

Children's health

Lyme disease

Injury (household, firearms, suicide)

HIV-infection

For more information about the data included in the report or to request data on other BRFSS measures, please contact Judith Graber in the Maine Bureau of Health at (207) 287-1420 or visit the national BRFSS website at www.cdc.gov/nccdphp/brfss.

Note: Numbers for Maine on the website may be somewhat different than those in this report because a slightly different sample was used for the CDC data.

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